BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **STEPHEN FLYNN, M.D.** Holder of License No. **3351** For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-05-0653A** **INTERIM FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR SUMMARY SUSPENSION OF LICENSE**

INTRODUCTION

The above-captioned matter came on for discussion before the Arizona Medical Board ("Board") on January 30, 2006. After reviewing relevant information and deliberating, the Board considered proceedings for a summary action against the license of Stephen Flynn, M.D. ("Respondent"). Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License, pending formal hearing or other Board action. A.R.S. § 32-1451(D).

INTERIM FINDINGS OF FACT

1. The Board is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 3351 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0653A after receiving a complaint from a thirty-two year-old female patient ("MH") alleging Respondent's office was unclean and unsanitary; he did not wear gloves when taking blood samples; he did not use an alcohol swab to disinfect the skin before giving injections; and he administers injections to patients in the waiting room.

4. On January 26, 2006 Board Staff conducted a site visit at Respondent's office. The site visit revealed MH had accurately described the conditions in Respondent's office. Respondent's office is located in a converted home and has two examination rooms, Respondent's office, two restrooms, a kitchen and an area for a receptionist. While waiting to be introduced to Respondent, Board Staff observed two men (one elderly, one young) approach the reception desk. The elderly man was later identified as SP. After some conversation between the receptionist and SP, the receptionist called out that "he needs a tetanus and MMR." Respondent came from the back, leaned over the reception counter and administered the immunization directly into SP's upper arm without prepping the injection site with alcohol or by any other method. Board Staff did not observe Respondent conduct any examination of SP. The younger man paid cash for SP's injection and asked for a receipt. The receptionist told him a receipt was not necessary. The receptionist also told them to return in two weeks, or earlier, if the site where Respondent administered SP's TB test became bigger than a quarter.

5. Immediately after injecting SP Respondent met another man in the examination room located just off the reception area. The man sat in a chair and Respondent sat next to him. Board Staff was able to observe to man's body and Respondent's arms. Respondent applied a tourniquet to the man's right arm and proceeded to draw blood from the arm. Respondent used a vacutainer with what appeared to be a new needle. Respondent did use a pre-packaged alcohol pad to prep the area. Respondent then tossed the used vacutainer and needle on the examination table without replacing the cap on the needle. Board Staff introduced themselves to Respondent after this blood draw and presented him with a notice of inspection. Respondent took Board Staff on a tour of his office.

6. During the tour, Board Staff observed the following: a) the examination table in the room used for blood draws was littered with used syringes, paper, and scrub towels; b) there were a few boxes of sterile syringes in the room and one sharps container on the sink; c) the sink counter was littered with papers, containers, and a cold sterile tray. The tops of the counters and cols sterile tray were caked with crystals and grime; d) although Respondent reported he uses Cidex (a clear, pale pink liquid) as a cold sterile solution and changes it approximately every three months, the solution in the cold sterile tray was a slightly viscous, dark orange liquid; e) the restrooms were generally clean, but had trash overflowing from the waste baskets (the public restroom had a re-purposed dish soap bottle labeled for hand washing and was nearly empty); f) the kitchen area was used for food preparation and pharmacy; g) the dining area of the kitchen was cluttered with boxes, papers, and old office equipment; h) bottles of Amoxicillin, Metronidazole, Zinc, and silver nitrate sticks were observed on the shelves. The medications were not expired, but the silver nitrate sticks appeared to be decades old; i) one side of the sink counter held dishes that appeared set out to dry and the other side held a centrifuge and a haphazard stack of laboratory requisition form copies; j) patient files, a fax machine, and the financial transaction were located in the receptionist's area behind the front counter; k) there was no appointment book or log and Respondent reported they were not necessary because he always remembered when his patients were coming in; and l) there was no obvious financial tracking system and patients were not given receipts. During the tour Respondent reported to Board Staff he did not keep any records on the patient he immunized, he just remembered what they needed.

7. The patients observed by Board Staff were immigrants obtaining the necessary medical documentation for residency requirements. Board Staff asked for the

medical records of SP and pulled five other charts at random. The medical record for SP consisted of two pages stapled together. The first page was the United States Department of Justice Form I-693 titled "Medical Examination of Aliens Seeking Adjustment of Status." The second page was a supplemental form to the I-693 – the immunization record. A manila folder labeled "RA and TF" contained medical records for RA, an FA and a JTA and an operative report for a CMA dated October 23, 1986. The surname of CMA is not the same as that for RA, FA, and JTA. A manila folder labeled "MM" contained one radiology report for MM and a photocopy of an insurance card for a DM. A manila folder labeled "T, M-S" contained chemistry results for MT dated September 28, 1998 and January 12, 2002 and an x-ray requisition form for ST dated September 23, 1998. A manila folder labeled "WP" contained a laboratory report dated December 18, 2004. A manila folder labeled "W, M/T" contained insurance forms and mammogram reports for TW and TLS (presumably the same patient). The most recent documentation was dated March 28, 1999.

8. Respondent is required to maintain adequate medical records. Specifically, he must maintain legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2).

9. The standard of care requires Respondent to maintain sanitary conditions and comply with hygienic procedures and standards in his treatment of patients, including prepping the patient's skin with an alcohol wipe prior to administering immunizations or conducting TB tests.

10. Respondent failed to maintain sanitary conditions and comply with hygienic procedures and standards in his treatment of patients.

11. Respondent's failure to meet the standard of care subjected his patients to potential harm including, increased injection site reactions or skin infections.

12. The standard of care required Respondent to perform examinations on patients prior to administering injections.

13. Respondent failed to perform examinations prior to administering injections.

14. Respondent's patients were subject to the potential harm of undiagnosed conditions that may have indicated the injection should not be given.

15. The facts as presented demonstrate that the public health, safety or welfare imperatively requires emergency action.

INTERIM CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent, holder of License No. 3351 for the practice of allopathic medicine in the State of Arizona.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient;") 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public;") and 32-1401(27)(t) ("[k]nowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution.")

3. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the public health, safety or welfare imperatively requires emergency action. A.R.S. § 32-

1451(D).

ORDER

Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth above, IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice allopathic medicine in the State of Arizona, License No. 3351, is summarily suspended pending a formal hearing before an Administrative Law Judge from the Office of Administrative Hearings.

2. The Interim Findings of Fact and Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against him. Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible after the issuance of this order.

3. The Board's Executive Director is instructed to refer this matter to the Office of Administrative Hearings for scheduling of an administrative hearing to be commenced as expeditiously as possible from the date of the issuance of this order, unless stipulated and agreed otherwise by Respondent.

DATED this 30th day of January 2006.

[S E A L]

ARIZONA MEDICAL BOARD

By _____
Timothy C. Miller, J.D.
Executive Director

ORIGINAL of the foregoing filed this 30th day of January, 2006, with:

Arizona Medical Board
9545 East Doubletree Ranch Road

Scottsdale, Arizona 85258

EXECUTED COPY of the mailed by certified mail this 30th day of January 2006 to:

Stephen Flynn, M.D.
(Address of record)

Executed copy of the foregoing mailed by first class mail this 30th day of January 2006 to:

Dean Brekke
Assistant Attorney General
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